WELCOME TO OUR PRACTICE

Sydney CBD Dental
...Making the City Smile

Dr Mark Sinclair
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At Sydney CBD Dental we strive to provide you with the highest possible care. To do this, we need to collect personal information from you. Without this information it is difficult for your Dentist or Hygienist to plan your individual care.

PLEASE COMPLETE FORM IN BLOCK LETTERS

Patient Details

Title: ☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Dr ☐ Other _____

Surname: _____

Given Name: _____

Preferred Name: _____

Date of Birth: _____/_____/_____

Residential Address: _____

_____

Suburb: _____

Postcode: _____

Email Address: _____

Contact: (home) _____

Contact: (mobile) _____

Contact: (work) _____

Occupation: _____

Private Health Fund: _____

Member Number: _____

Series Number: _____

General Practitioner: _____

Contact Number: _____

Emergency Contact Name: _____

Contact Number: _____

Relation: _____

Reminder System:
Please indicate your preferred method of contact:

☐ SMS ☐ Mobile ☐ Home Phone
☐ Work Phone ☐ Email

How Did You Hear About Us?

☐ Referred by Family, Friend or Colleague?
Whom may we thank? _____
☐ Website/Google search
☐ Bupa Retail Store
☐ Bupa Website
☐ Practice Signage
☐ Other: Please specify: _____

Medical History: *Please tick appropriate box below*

☐Y ☐N Abnormal Bleeding
☐Y ☐N Artificial Heart Valve
☐Y ☐N Asthma
☐Y ☐N Blood Pressure ☐High ☐Low
☐Y ☐N Bisphosphonates *ie Fosamax*
☐Y ☐N Cardiac Surgery/Pacemaker
☐Y ☐N Diabetes ☐Type 1 ☐Type 2
☐Y ☐N Do you snore or experience restless sleep?
☐Y ☐N Eating Disorder
☐Y ☐N Epilepsy
☐Y ☐N Joint Replacement: _____
☐Y ☐N Heart Conditions

☐Y ☐N Hepatitis ☐A ☐B ☐C
☐Y ☐N HIV Positive
☐Y ☐N Pregnant: *Due date*: _____
☐Y ☐N Radiation or Chemotherapy
☐Y ☐N Rheumatic Heart Disease
☐Y ☐N Smoker: *How many per day*: _____
☐Y ☐N Warfarin Medication
☐Y ☐N **Are you taking any medications?**
If yes, please list: _____
_____
_____
_____

Other: _____

Allergies:

☐Y ☐N Penicillin ☐Y ☐N Aspirin ☐Y ☐N Iodine ☐Y ☐N Sulpha Drugs ☐Y ☐N Latex

Other (Specify all allergies): _____

Please turn over to complete your medical history form

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Dental History

Last Visit to the Dentist: _____ / _____ / _____

Have you ever had any reaction or complication following dental treatment in the past? *If yes, please detail:*

_____

Is there anything else the Dentist or Hygienist should be aware of? _____

Are you suffering from any of the following? Please tick.

☐ Toothache	☐ Missing Teeth	☐ Sounds from Joint
☐ Sensitive Teeth	☐ Unsatisfactory Denture	☐ Difficulty Chewing
☐ Bleeding Gums	☐ Lost Filling/Cavity	☐ Discoloured Teeth, Would you like Whiter Teeth? ☐Y ☐N
☐ Loose Teeth	☐ Grinding/Clenching Teeth	☐ Bad Appearance of Teeth
☐ Bad Breath	☐ Worn, Broken Teeth	☐ Wisdom Teeth
☐ Dry Mouth	☐ Pain in Face or Jaw Joints	☐ Other: Please specify: _____

Privacy and Consent

- Please be assured any information is collected and maintained in accordance with State and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask our staff for "personal Information, Privacy and your Dentist" document.
- I have accurately completed this medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume all financial responsibility for all treatment.
- I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made. We do not offer credit for treatment at Sydney CBD Dental however we do recommend a number of agencies that may offer financial assistance. Please ask our friendly staff members.
- I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.
- *I understand and accept that Sydney CBD Dental requires a minimum of 48 hours notice for cancelling or rebooking appointments. All appointments not attended will be charged at a rate of $75.00. Thank You.*

☐ Yes! I would like to receive a newsletter and be among the first to receive special offers, practice announcements and free dental advice and information from my dental practice.

Patient's Signature: _____ Date: _____

(Parent or guardian to sign if patient is a minor)